IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. BUTCH OTTER, GOVERNOR
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

October 23, 2008

Joseph Messmer
Mercy Medical Center
1512 Twelfth Avenue Road
Nampa, Idaho 83686

RE: Mercy Medical Center, provider #130013

Dear Mr. Messmer:

This is to advise you of the findings of the Medicare/Licensure survey at Mercy Medical Center which was concluded on October 2, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **November 5, 2008**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/mlw

Enclosures

Mercy Medical Center

November 3, 2008

Mr. Gary Guiles
Health Facility Surveyor
ID Department of Health & Welfare
3232 Elder Street
Boise, ID 83720

Ms. Sylvia Creswell
Co-Supervisor
ID Department of Health & Welfare
3232 Elder Street
Boise, ID 83720

RE: MERCY MEDICAL CENTER, PROVIDER #130013
STATEMENT OF DEFICIENCIES/PLAN OF CORRECTION, FORM CMS-2567 (MEDICARE DEFICIENCIES/STATE LICENSURE DEFICIENCIES)

Dear Mr. Guiles and Ms. Creswell:

I would once again like to thank you and your staff for taking the time to come to our facility and assist us with some corrections that needed to be made. Your time and efforts were appreciated by all involved.

Per your request, I am enclosing the completed CMS-2567 form pertaining to the above-referenced deficiencies.

Should you have any questions or concerns please do not hesitate to contact me.

Sincerely,

Clint Child
V.P. of Patient Care/CNO

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130013	A. BUILDING _____ B. WING _____	10/02/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY MEDICAL CENTER	1512 TWELFTH AVENUE ROAD NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your hospital. The surveyors conducting the survey were: Gary Guiles, RN, HFS, Team Leader Patricia O'Hara, RN, HFS Teresa Hamblin, RN, MS, HFS Patrick Hednrickson, RN, HFS	A 000	RECEIVED NOV 04 2008 FACILITY STANDARDS	
A 442	482.24(b)(3) SECURITY OF MEDICAL RECORDS [Information from or copies of records may be released only to authorized individuals,] and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the hospital failed to ensure the security of patient records. This had the potential to allow unauthorized individuals access to patient records. Findings include: During a tour on 9/29/08 at 2:20 PM, surveyors observed medical records in cubbies outside of patient rooms on the Medical, Surgical, and Orthopedic units. Patient initials and physician names were visible on the outside of each chart. Surveyors sampled patient charts and viewed information, such as patient demographics, history and physicals, test results, vital signs, and legal forms. The charts could be easily removed from the cubbies and were left unattended at times while hospital staff worked in patient rooms or at the nursing station. During an interview on 9/29/08 at 2:40 PM, the	A 442	As of December 31, 2008, the medical records on Medical Surgical Unit 3 and Orthopedic Unit 4 will be secured behind locked cabinet doors. This will prevent unauthorized access of the medical records. The Director of Facilities and the Director of the Medical and Surgical Units will monitor the security of the medical records via weekly observation audits for a total of four weeks and randomly thereafter.	12/31/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Pres/CEO	10/30/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 442	Continued From page 1 Director of the Medical/Surgical units confirmed that patient chart information was routinely kept in the hallways. She further stated that having charts in the hallways had not been a problem. The hospital failed to ensure patient records remained secured and/or attended.	A 442		
A 466	482.24(c)(2)(v) CONTENT OF RECORD - INFORMED CONSENT [All records must document the following, as appropriate:] Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent. This STANDARD is not met as evidenced by: Based on interview and review of hospital policies and patient records, it was determined the hospital failed to ensure proper execution of 4 informed consents in 2 of 5 sampled patients (#'s 29, 17) requiring procedural consent. This resulted in dates and/or times being omitted from the consent forms. Missing documentation had the potential to introduce doubt that patients gave consent prior to the procedure. Findings include: A. Hospital Consent Policy An undated hospital policy for Consent (Administrative Policy #128), stated "Prior to an operative/invasive procedure, an informed consent form will be completed including "... the time and date the form is signed by the patient or the patient's legal representative." B. Patient Records and Staff Interviews	A 466	On October 30, 2008, the electronic medical record (including the OR Preoperative Assessment, the Day Surgery Checklist and the Blood Administration Checklist) was modified to include a forced concurrent review of the presence of the date and the time on consents for all operative/invasive procedures. The changes were approved at Documentation Oversight Committee. On October 31, 2008, the trial format medical record changes were made active in the live electronic medical record. By December 31, 2008, the nursing staff will be informed and educated regarding the necessity of dating and timing patient signatures on informed consents, and regarding the changes to the electronic medical record tools (OR Preoperative Assessment, Day Surgery Checklist, and Blood Administration Checklist).	10/30/08 10/31/08 12/31/08

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A 466	Continued From page 2 1. Patient #29 was a 50 year old woman admitted to the hospital on 9/22/08 with gastrointestinal hemorrhage. Surveyors found in the patient's records three undated and untimed consent forms involving invasive procedures. During an interview on 10/2/08 at 11:02 AM, a Nursing Manager confirmed the consents were not dated or timed. 2. Patient #17 was a 60 year old woman with a preoperative diagnosis of lumbar spinal stenosis. Surveyors found one untimed consent, dated 9/3/08, in the patient's record. The consent was for general anesthesia related to a laminectomy. During an interview on 10/2/08 at 11:02 AM, a Nursing Manager confirmed the consent was not timed. The hospital failed to ensure that staff obtained proper informed consent.	A 466	By December 31, 2008, the hospital policy for Consent (Administrative Policy #128) will be updated to ensure compliance with current Federal and State law. The policy will be amended to reflect the date of approval. Consents in the medical records will be audited during December 2008 to assure 100% compliance to signature, date and time.	12/31/08
A 467	482.24(c)(2)(vi) CONTENT OF RECORD - OTHER INFORMATION [All records must document the following, as appropriate:] All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition. This STANDARD is not met as evidenced by: Based on staff interview, review of patient records, and review of the medication administration system, it was determined the hospital failed to ensure all necessary medical information was included in the Emergency Department (ED) record of 1 of 12 patients (#30) whose records were reviewed. This failure to	A 467	On October 6, 2008, the prescriber is required to document the rationale for prescribing a medication that a patient has a documented allergy. The override comments are currently stored in the electronic medical record and are reproducible upon demand. During October, medical records were audited to assure compliance of the documented override.	10/6/08

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A 467	Continued From page 3 document in the patient's record lead to confusion as to whether the physician intentionally or unintentionally ordered an antibiotic for a patient with a known allergy to the medication. The patient developed an allergic reaction that required a second ED visit. 1. Patient #30 was a 79 year old male who presented to the ED on 8/28/08 with difficulty breathing. The record documented that the patient was diagnosed with pneumonia and sent home with a prescription for the antibiotic Levofloxacin (AKA Levaquin). The medication record documented the patient had known allergies to multiple antibiotics, including Levaquin, and that the type of reaction to Levaquin was not known. No documentation was found in the clinical record that offered a rationale for ordering the antibiotic despite the known allergy. Two days later, on 8/30/08, the patient returned to the ED with a rash. The ED Patient Summary record, dated 8/30/08, documented the patient was diagnosed with an allergic reaction to Levaquin, given intravenous Benadryl (a medication to counteract the effects of the allergy) and sent home on a different antibiotic. The physician who ordered the medication was not available for interview. During an interview on 10/1/08 at 9:54 AM, a senior staff pharmacist explained that it would be unlikely a physician would order Levaquin for a patient with a known allergy to Levaquin and the type of reaction was unknown. During an interview on 10/2/08 at 8:18 AM, the	A 467		

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A 467	Continued From page 4 Director of the ED explained that the ED used the Meditech computer system which alerted the practitioner to known allergies when medications were entered into the system. In order to continue ordering a medication for a patient with a known allergy to the medication, the practitioner had to over-ride the system by putting in a rationale for continuing with the order. The ED Director stated it was her opinion that the physician intentionally ordered the medication because the patient was allergic to so many different antibiotics and the pneumonia needed to be treated. The rationale for the over-ride did not print in the medical record. Surveyors requested hospital staff provide a copy of the physician's entry into the Meditech system showing the rationale the physician entered into the system. They were unable to retrieve the computer information prior to surveyor's exiting the hospital. According to the Risk Management and Clinical Quality Specialist during an interview on 9/30/08 at 1:49 PM, the Meditech system did not print the over-ride information into the medical record. This glitch in the computer system had the potential to omit important medical information from the patient's medical record. If the over-ride information had printed in the medical record, it would have been more clear that the physician was making a considered decision to order the medication. The hospital failed to ensure that essential information was included in the medical record.	A 467		

Bureau of Facility Standards

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BB275	16.03.14.360.04 Access to Records 04. Access to Records. Only authorized personnel shall have access to the record. (10-14-88) This Rule is not met as evidenced by: Refer to Federal Tag 442 as it relates to the hospital's failure to secure medical records and prevent access of medical records to unauthorized individuals.	BB275	By December 31, 2008, the medical records on Medical Surgical Unit 3 and Orthopedic Unit 4 will be secured behind locked cabinet doors. This will prevent unauthorized access of the medical records. The Director of Facilities and the Director Medical and Surgical Units will monitor the security of the medical records and via weekly observation audits for a total of four weeks and randomly thereafter.	12/31/08
BB283	16.03.14.360.12 Record Content 12. Record Content. The medical records shall contain sufficient information to justify the diagnosis, warrant the treatment and end results. The medical record shall also be legible, shall be written with ink or typed, and shall contain the following information: (10-14-88) a. Admission date; and (10-14-88) b. Identification data and consent forms; and (10-14-88) c. History, including chief complaint, present illness, inventory of systems, past history, family history, social history and record of results of physical examination and provisional diagnosis that was completed no more than seven (7) days before or within forty-eight (48) hours after admission; and (5-3-03) d. Diagnostic, therapeutic and standing orders; and (10-14-88) e. Records of observations, which shall include the following: (10-14-88) i. Consultation written and signed by consultant	BB283	On October 30, 2008, the electronic medical record (including the OR Preoperative Assessment, the Day Surgery Checklist, and the Blood Administration Checklist) was modified to include a forced concurrent review of the presence of the date and the time on consents for all operative/invasive procedures. The changes were approved at Documentation Oversight Committee. On October 31, 2008, the trial format medical record changes were made active in the live electronic medical record.	10/30/08 10/31/08

RECEIVED
NOV 04 2008
FACILITY STANDARDS

Bureau of Facility Standards

Joseph A. Mer
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Pres/COO

(X6) DATE: 10/30/08

Bureau of Facility Standards

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BB283	Continued From page 1 which includes his findings; and (10-14-88) ii. Progress notes written by the attending physician; and (10-14-88) iii. Progress notes written by the nursing personnel; and (10-14-88) iv. Progress notes written by allied health personnel. (10-14-88) f. Reports of special examinations including but not limited to: (10-14-88) i. Clinical and pathological laboratory findings; and (10-14-88) ii. X-ray interpretations; and (10-14-88) iii. E.K.G. interpretations. (10-14-88) g. Conclusions which include the following: (10-14-88) i. Final diagnosis; and (10-14-88) ii. Condition on discharge; and (10-14-88) iii. Clinical resume and discharge summary; and (10-14-88) iv. Autopsy findings when applicable. (10-14-88) h. Informed consent forms. (10-14-88) i. Anatomical donation request record (for those patients who are at or near the time of death) containing: (3-1-90) i. Name and affiliation of requestor; and (3-1-90)	BB283	By December 31, 2008, the nursing staff will be informed and educated regarding the necessity of dating and timing patient signatures on informed consents, and regarding the changes to the electronic medical record tools (OR Preoperative Assessment, Day Surgery Checklist, and Blood Administration Checklist). By December 31, 2008, the hospital policy for Consent (Administrative Policy #128) will be updated to ensure compliance with current Federal and State law. The policy will be amended to reflect the date of approval. Consents in the medical records will be audited during December 2008 to assure 100% compliance to signature, date and time. On October 6, 2008, the prescriber is required to document the rationale for prescribing a medication that a patient has a documented allergy. The override comments are currently stored in the electronic medical record and are reproducible upon demand. During October, medical records were audited to assure compliance of the documented override.	12/31/08 12/31/08 10/6/08

Bureau of Facility Standards

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BB283	Continued From page 2 ii. Name and relationship of requestee; and (3-1-90) iii. Response to request; and (3-1-90) iv. Reason why donation not requested, when applicable. (3-1-90) This Rule is not met as evidenced by: Refer to Federal Tag 467 as it relates to the hospital's failure to ensure necessary medical information was available in patient records.	BB283		

IDAHO DEPARTMENT OF
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

January 20, 2009

Joseph Messmer
Mercy Medical Center
1512 Twelfth Avenue Road
Nampa, Idaho 83686

Provider #130013

Dear Mr. Messmer:

On **October 2, 2008**, a complaint survey was conducted at Mercy Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003770

Allegation: The hospital failed to investigate the causes of a patient's illness and failed to provide timely consultations with specialist providers. Also, a physician failed to cooperate with a patient's request to transfer to a hospital that offered more services.

Findings: Surveyors made an announced visit to the hospital, entering on 9/29/08 and exiting on 10/2/08. During the complaint investigation, surveyors interviewed staff and reviewed 30 patient records. In conjunction with the investigation, a complete Medicare recertification survey was conducted.

One clinical record documented a 42 year old male admitted to the emergency room (ER) on the evening of 8/7/08 complaining of hiccups. He was treated and released. He returned to the ER at 11:23 AM on 8/8/08 with a facial droop and left sided deficit. Laboratory testing and computerized tomography (CT Scan) were performed. Magnetic resonance imaging was performed. The patient was diagnosed with a stroke and admitted to the intensive care unit (ICU) at approximately 6:00 PM. Aspirin 325 mg was ordered for each AM but a first dose was documented as given at 7:13 PM.

A physician discharge summary, dated 8/9/08, stated the patient's family requested the patient be transferred to a Boise Idaho hospital after the patient had been admitted to the ICU. The summary stated the physician called both Boise hospitals. The summary said one hospital did not have a neurologist on call. The neurologist at the other hospital told the Mercy Medical Center physician that he, the neurologist, would accept the patient for care but the Boise hospital did not currently have a tele-monitored bed. The summary stated the patient was told he would be transferred as soon as a bed became available. The summary stated "the patient's family once again insisted on going against medical advice, essentially to the ER of (the Boise) Hospital."

A physician communication note, dated 8/8/08, Written by a registered nurse (RN) stated "MD notified of patient request to be transferred to (hospital name). MD at this time feels that patient is not a candidate for transfer to neurological unit at this time due to nature of ischemic infarct, and that patient would be managed well at this facility by treating symptoms. Patient and family notified at this time of MD decision not to transfer patient at this time." A nursing note, dated 8/9/09, stated "Patient and spouse notified at 20:20 of MD decision not to transfer pt to (hospital name). Patient and spouse agree that at this time they choose to leave AMA and seek treatment elsewhere-primarily (name of hospital)." Though there was some conflicting documentation, it could not be determined that the patient's rights were violated.

The ICU nurse, who cared for the above patient, was interviewed on 10/2/08 at 7:35 AM. She stated a neurologist was not available at the hospital. She stated the hospital physician attempted to meet the wishes of the patient's family but was unable to do so. She said the hospital was willing to assist with arranging the transfer but the patient and family chose to discharge the patient against medical advice. The hospitalist who cared for the patient was also interviewed, on 10/2/08 at 1:00 PM. He stated he had stayed with the patient until 8:00 PM on 8/8/08. He stated a neurologist was not on call but said he had consulted with a neurologist by telephone and both physicians had agreed the patient could be treated with aspirin and without a neurological consult. He said he agreed to transfer the patient when a bed became available. He said the family chose to discharge the patient against medical advice and take him to the ER at the Boise hospital, which they did.

All of the patient records reviewed contained documentation patients were treated in a timely manner. Physicians had been appropriately credentialed and granted privileges by the hospital. An active peer review process was in place at the hospital to review the work of the physicians. The patient noted above was assessed by a qualified physician and a plan of care was implemented. Questions of the appropriateness of diagnosis and treatment decisions are not addressed by federal or state hospital regulations.

Because of the absence of regulations, survey staff did not attempt to determine if the patient received the best care for his diagnosis. The hospital was determined to be in compliance with the process requirements for the medical staff.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/mlw